

**This is for your first month's payment only.**

If you would like to continue to make payments this way, please contact us at **1-800-731-4661**. Please note that Kaiser Permanente does not accept credit card payments for initial or ongoing premium payments for small group insurance.

Company name (please print)		Customer ID
Street address (no P.O. boxes)		
City	State	ZIP

I authorize Kaiser Permanente and the designated financial institution to withdraw the amount of the first month's premium only from the company checking account identified below.

Amount of first month's premium: \$ \_\_\_\_\_

Transit routing number: \_\_\_\_\_ Bank account number: \_\_\_\_\_

If this item is returned unpaid, I authorize Kaiser Permanente to resubmit the item and charge this account an additional returned check fee for the maximum amount allowed by the state. I also acknowledge that Kaiser Permanente will not be responsible for any fees incurred if an original check is mailed and cashed.

Name (please print)	Title
Signature X	Date

This debit will appear on your next bank statement as a transaction from *Kaiser Permanente*.

**Return this form, along with your *New Group Application*, to your Kaiser Permanente sales representative or your broker.**

**Confidentiality note:** This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information in the transmission is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments. Thank you.